VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 4, 2015

Ms. Debra Clemmer, Manager
Lakeview Community Care Home
322 St Paul Street
Burlington, VT 05401-4647

Dear Ms. Clemmer:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 1, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	C 04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHDULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site investigation of self-reported incidents was conducted by the Division of Licensing and Protection on 4/1/15. The following regulatory violations were identified.	R100		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed through staff interviews the home failed to assure that an assessment was conducted following a change in condition requiring hospitalization for 2 of 5 residents reviewed. (Residents #2 and #5). Findings include: 1. Per record review, Resident #2, who was exhibiting an escalation of verbally and physically aggressive behaviors towards others had an evaluation conducted by a physician and a crisis worker on 2/18/15, resulting in a hospital admission for the resident. Despite the change in condition, requiring hospitalization, the most current Resident Assessment was dated 5/12/14. 2. Per review of Resident #5's record the most current Resident Assessment was dated 8/15/14. Although the resident had a change in his/her mental condition requiring an extended	R136	See enclosed response	

R136, R145 + R224 POC's accepted 6/4/15 PMcotaRN

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R136	Continued From page 1 hospitalization from which she was readmitted to the home on 3/4/15, no reassessment had been conducted. The home's RN Supervisor confirmed, during interview at 3:00 PM on 4/1/15, that Residents #2 and #5 had each undergone a change in their mental or physical condition, reassessments had not been completed as of the date of survey.	R136		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home failed to assure that written plans of care had been developed and/or revised to address all current needs for 3 of 5 residents reviewed. (Residents #1, #2 and #5). Findings included: 1. Per review of Resident #1's record, a clinical note, dated 12/27/14 stated; "Last night [Resident #1] cornered [Resident #7] by [his/her] bedroom. [Resident #7] was yelling for help over and over and when staff got upstairs [Resident #1] was just laughing about it..." A note on 1/3/15 stated; "...heard...[Resident #3] arguing with [Resident #1]. By the time writer could get out of the office... [Resident #1] had pushed [Resident #3] to get by	R145		

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R145	Continued From page 2 [him/her] also hitting [Resident #3] in the arm in passing..." A note on 3/24/15 stated: 'staff heard [Resident #6] yelling from the common area... [Resident #6] had hit [Resident #1] in the face two times...[Resident #6] said that [Resident #1] kept going into his/her room and that [Resident #1] had "slapped [Resident #6]..." Although a note, dated 3/30/15, indicated that Resident #1 had been transferred to a room on the first floor so that staff could more closely monitor the resident, and despite the fact that the resident's treatment plan identified that the resident is often aggressive towards other residents, the treatment plan did not include interventions for specific frequency of monitoring of Resident #1 to prevent aggressive and abusive behavior targeted towards other residents. 2. Per record review Resident #2, admitted on 5/16/13 with a diagnosis that included Paranoid Schizophrenia with delusions, exhibited verbal and/or physically aggressive behaviors towards other residents during the following documented incidents: On 1/6/15 a clinical note stated that "... [Resident #2] had pushed and then punched [Resident #4 - who is significantly visually impaired] in the stomach.." A note on 2/5/15 stated: "...does show elevated signs of aggressive behavior....[S/he] can be very rude and vulgar and aggressive towards staff and other residents equally." On 2/11/15 the record indicated; "[Resident #2] continues to show aggressive behavior towards other residents....hasn't hit anyone but [s/he] will make aggressive gesture at others as if [s/he] wants to strike someone...." On 2/12/15 a note stated: "staff heard [Resident #2] yelling outside at [Resident #4]...[Resident #4] reported that [Resident #2] grabbed [his/her] hat off [his/her] head and threw it into the snow. "[Resident #2]	R145		

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R145	Continued From page 3 had been yelling at and insulting staff and residents right before this happened." A subsequent note on 2/14/15 stated that [Resident #2]: " ....went up to [Resident #4] and grabbed [his/her] hat and threw it outside into the snow...This was the second time this week that [Resident #2] grabbed [Resident #4's] hat and threw it into the snow...[Resident #4] remains upset about the incident..." And, another note on 2/15/15 again stated: "today at coffee time [Resident #2]... turned toward [Resident #4] pulled his/her hat off....and threw it on the floor...Yesterday after the incident with [Resident #4] staff attempted to verbally counsel [Resident #2] and [Resident #2]...made verbal threats of violence." A note on 2/18/15 indicated that [Resident #2] was once again "yelling and in a [Resident #7's] face..." and the police were subsequently called. Resident #2 was also evaluated by a physician and a crisis worker and admitted to the hospital on that date. Although Resident #2's treatment plan reflected "staff is keeping a close eye on...because sometimes in [his/her] rage, [s/he] gets aggressive towards other residents..." the plan does not specify any frequency for staff monitoring of the resident. 3. Per record review Resident #5 had exhibited verbally and/or physically aggressive behaviors towards other residents on several occasions. A clinical note on 12/18/14 stated: "It has come to writers attention that [Resident #5] is continuing to bully people. [S/he] is bullying at least two people for cigarettes and at least one person for money....suspect [s/he] is bullying [Residents #8 and #9] for cigarettes and money. Writer will, with other staff help try to keep an eye out on [Resident #5] to reduce [his/her] bullying." A note dated 3/5/15 stated; "[Resident #5] was up yelling last night [at Resident #6]..." And, a subsequent	R145		

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R145	Continued From page 4 note, on 3/13/15 stated; "[Resident #5] is...bullying, demanding, yelling...I am going to slap your face to people the majority of the time..." Despite the evidence of ongoing aggressive behavior towards other residents, Resident #5's treatment plan did not include specific interventions for frequency of staff monitoring to prevent the resident from targeting other residents with these behaviors. The RN Supervisor confirmed, during interview at 3:00 PM on the afternoon of 4/1/15, that Residents #1, #2 and #5 had exhibited verbally and/or physically aggressive and abusive behaviors towards other residents. S/he further confirmed that, despite these incidents no specific plan had been devised that identified the frequency of monitoring of these residents to prevent them from targeting other residents with the behaviors.	R145		
R224 SS=E	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the home failed to assure that all residents were free from the repeated verbal and/or physical abuse from Residents #1, #2, and #5. (Residents #3, #4, #6, #7, #8 and #9). Findings include:	R224		

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R224	Continued From page 5 Per record review Residents #1, #2 and #5 engaged in the following verbally and/or physically aggressive and abusive behaviors towards other residents of the home on multiple occasions between December of 2014 and March 24, 2015: 1. Per review of Resident #1's record a clinical note, dated 12/27/14 stated; "Last night [Resident #1] cornered Resident #7 by [his/her] bedroom. Resident #7 was yelling for help over and over and when staff got upstairs Resident #1 was just laughing about it....." A note on 1/3/15 stated; ".....heard another resident [#3] arguing with [Resident #1]. By the time writer could get out of the office....[Resident #1] had pushed [Resident #3] to get by [him/her] also hitting [Resident #3] in the arm in passing...." A note on 3/24/15 stated: 'staff heard [Resident #6] yelling from the common area.... [Resident #6] had hit [Resident #1] in the face two times...[Resident #6] said that [Resident #1] kept going into his/her room and that [Resident #1] had "slapped [Resident #6]..." Although a note, dated 3/30/15, indicated that Resident #1 had been transferred to a room on the first floor so that staff could more closely monitor the resident, there was no evidence that interventions had been implemented to assure ongoing monitoring of Resident #1 to prevent him/her from targeting other residents with the aggressive and abusive behavior. 2. Per record review Resident #2, admitted on 5/16/13 with a diagnosis that included Paranoid Schizophrenia with delusions, had a clinical note on 1/6/15 that stated; ".....[Resident #2] had pushed and then punched [Resident #4 - who has significant visual impairment] in the stomach.." A note on 2/5/15 stated: "...does show elevated signs of aggressive behavior....can be very rude and vulgar and aggressive towards staff and other residents equally." On 2/11/15 the record indicated; "[Resident #2] continues to show	R224		

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R224	Continued From page 6	R224		

aggressive behavior towards other residents....hasn't hit anyone but [s/he] will make aggressive gestures at others as if [s/he] wants to strike someone...." On 2/12/15 a note stated: "staff heard [Resident #2] yelling outside at [Resident #4]..[Resident #4] reported that [Resident #2] grabbed [his/her] hat off [his/her] head and threw it into the snow. "[Resident #2] had been yelling at and insulting staff and residents right before this happened." A subsequent note on 2/14/15 stated that Resident #2: "....went up to [Resident #4] and grabbed [his/her] hat and threw it outside into the snow.....This was the second time this week that [Resident #2] grabbed [Resident #4's] hat and threw it into the snow.....[Resident #4] remains upset about the incident..." And, another note on 2/15/15 again stated: "today at coffee time [Resident #2]..... turned toward [Resident #4] pulled his/her hat off....and threw it on the floor...Yesterday after the incident with [Resident #4] staff attempted to verbally counsel [Resident #2] and [Resident #2].....made verbal threats of violence." A note on 2/18/15 indicated that Resident #2 was once again "yelling and in [Resident #7's] face..." and the police were subsequently called. Resident #2 was also evaluated by a physician and a crisis worker and admitted to the hospital on that date.

3. Per record review Resident #5 had a clinical note on 12/18/14 that stated: "It has come to writers attention that [Resident #5] is continuing to bully people. [S/he] is bullying at least two people for cigarettes and at least one person for money....suspect [s/he] is bullying [Residents #8 and #9] for cigarettes and money. Writer will, with other staff help try to keep an eye out on [Resident #5] to reduce [his/her] bullying." A note dated 3/5/15 stated; "[Resident #5 was up yelling last night [at Resident #6]..." And, a subsequent

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R224	Continued From page 7 note, on 3/13/15 stated; "[Resident #5] is .....bullying, demanding, yelling.....I am going to slap your face to people the majority of the time...." Residential Counselors (RCs) #1 and #2 both confirmed during separate interviews at 3:10 PM and 3:20 PM, respectively, that Residents #1, #2 and #5 all engaged, at times, in targeting other residents with behaviors that include; bullying, harrassing, and verbally and/or physically aggressive and assaultive behaviors. Both RCs aknowledged the need, at times, for closer monitoring of each of these residents as an intervention to prevent the ongoing behaviors. The RN Supervisor confirmed, during interview at 3:00 PM on the afternoon of 4/1/15, that Residents #1, #2 and #5 had exhibited verbally and/or physically aggressive and abusive behaviors towards other residents. S/he further confirmed that, despite these incidents no specific plan had been identified for staff to monitor Residents #1, #2 and #5 on a more frequent basis to protect other residents from the abusive behaviors.	R224		

JUN 0 4 2015

Date: May 29, 2015

To: Pamela Cota

From: Debra Clemmer – Program Coordinator/RN - Lakeview Community Care Home D. Clemmer

Re: Plan of Action from the April 1, 2015 investigation of self-reported incidents

Deficiency R136: Residential-Assessments were not completed on two residents after they had a psychiatric hospitalization.

Action: Resident #2 reassessment was completed April 6, 2015. Resident #5 was re-hospitalized in early April and the reassessment was completed on her return to Lakeview May 29, 2015. In the future all residents who are hospitalized will have an assessment completed within 48 hours of their return to Lakeview by the registered nurse. The registered nurse will monitor compliance in this area.

Deficiency R145: Fail to assure that written plans of care had been developed and/or revised to address all current needs for 3 of 5 residents reviewed.

Action: Care plans for Residents #1, #2. and #5 were reviewed and revised to ensure appropriate interventions are present for all current needs and problems. All care plans were reviewed to ensure each resident has a plan of care that is based on abilities and needs identified in the resident assessment and each resident's plan of care describes the care and services necessary to assist the resident to maintain independence and well-being. When there is a change in status or behavior of residents, care plans will be reviewed and revised as needed. The registered nurse will be responsible for reviewing the revising care plans as needed when changes occur. The RN will review care plans every 3 months and within 3 days when there is a change in the resident's condition.

Deficiency R224: Failed to assure that all residents were free from repeated verbal and/or physical abuse.

Actions:

Resident #1 was moved to the main floor for increased observation from staff. The move was done in early April 2015. Resident #2 and #5 both had recent psychiatric hospitalizations to address their aggression and medication changes were made. A new change that was implemented early April 2015 is when two staff are working one staff will be in the common areas to observe residents more closely and intervene quickly when there is conflict. The Howard Center Start Team began visiting residents on an ongoing basis in early April 2015 to offer support for any resident that wants to talk with them. The Start Team staff is peers that have struggled themselves with mental health issues. Another change implemented in early April is that when a resident is escalated he/she will be offered an admission to Assist. The supervisor/registered nurse will monitor to ensure a staff person

is in the common areas/milieu on an ongoing bases. Supervisor/RN will monitor that resident rights are being respected on an ongoing bases.